WORLD HEALTH

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Europeans and their health

The European way to Health for All

by J. E. Asvall

Photo WHO

Welcome to Europe, its diversity, its challenges, its problems and its many successes! It is likely that most of you in good faith believe that you know us pretty well ... But I should like to introduce you to some different aspects of this Region.

Maybe more than any other WHO Region, ours is characterized by its diversity and apparent contradictions. Arctic regions and tropical deserts, poor and rich countries, an abundant mixture of cultures and ethnic groups, a wide range of political views, social systems, and approaches to health—a mixture of experiences and ideas. However, this we do not see as a problem at all. On the contrary, in our diversity of views and actions lies the very strength of a society that believes progress can only come through freedom to experiment, courage to be challenged by other views than your own and a willingness to continuously explore the most promising path ahead by sharing openly, with everyone, your own experience. Thus, in the European Region, we see diversity as being essential to our wealth and strength as an international community!

Geographically speaking, the Region spreads from the Pacific coast of the USSR in the east to Greenland in the west, the North Pole in the north to Israel and Turkey in the south. It has some 850 million inhabitants in 35 Member States; about half of them live in the eight countries that used to belong to what only two years ago was called the "Communist Bloc", but which are now going their, democratic and different, ways.

It is clear that, in a global perspective, our Region has the best indicators in health, but we also have our problems. One of them, which we have not managed to solve yet—despite our richness—is a glaring inequity in health. Indeed, there are important, yes tragic, differences in health between the human beings who live in our Region. For one who is born in any of the countries mentioned above, life expectancy will be 5–6 years less than for one who is born in the western part of the Region, while a newborn child in Turkey is even less fortunate. Furthermore, a child born to a lower class family in our most well-to-do countries, even today as we approach the year 2000, will live for 5–6 years less than a child born in an upper class family. We are not proud of this and that is why equity in health is the first of the 38 Health-for-All targets made by our Member States.

Building a common policy in health for Europe

When the European Regional Office was established, just over 40 years ago, its commitments were to face situations and problems that had arisen from the Second World War: rampant tuberculosis, high infant and maternal mortality and morbidity, poor nutrition, and poor housing and sanitation were our common challenges.

During the 1960s and 1970s, we built impressive hospitals and other health institutions, introduced massive technology and trained a large number of health personnel. At the beginning of the eighties, Europe took a sharp and honest look at itself; it clearly appeared that there were serious problems in health which were untouched: the unhealthy affluent life-styles, the decreasing quality of the environment and its effects on health, the unchecked development of health technologies—not always taking due account of patients' real needs—were but a few examples. It became apparent to the top European leaders in health, meeting in the WHO European Regional Office in 1980, that something was fundamentally wrong with the way countries went about trying to improve the health of their people. A new framework for health development was needed, one that could serve as a common policy for European countries and their people, and which, at the same time, would bring an inspirational framework for the formulation of each country's own health policy and development.

With this decision, a new area of health development in the European Region started. Based on the basic philosophy of the global Health-for-All strategy, an intensive effort was made in 1980 to develop a European health policy and 38 targets were specifically tailored to the needs, characteristics and possibilities of the European countries. Involving many hundreds of experts, from 25 scientific disciplines, the process also included an extensive written consultation with each individual Member State and three annual sessions of the Regional Committee.

It was an unprecedented step to design our own, very concrete, model towards the concept of Health for All, which, in 1984, all Member States in the Region endorsed as the Health-for-All policy, with 38 targets to reach by the year 2000. Keeping in line with the basic philosophy of target setting as a tool for systematic development, the Regional Committee in September 1991 updated the 38 targets in order to adjust for achievements made, and new strategic lessons learnt, since 1984.

Thus, we had developed a common language and a joint vision for the future. This led to a major debate, and then to profound changes in many countries. Today, a large majority of our Member States have designed entirely new health policies which are explicitly based on this European policy in health, and all countries of the Region have endorsed its values and approaches as being in line with their own wishes in health development.

The eradication of cigarette smoking: more difficult than that of smallpox?

Keeping up with the real challenges for Europe needs a different way of mobilizing society: the countries of

central and eastern Europe need to be lifted up and carried 20 years forward, in health terms, during the next ten years. Now that smallpox no longer exists, cigarette smoking, alcohol and other drugs, and misuse of medical technology are threats of even greater magnitude and difficulty. I should just mention that among the 850 million people who live in Europe today, 100 million are likely to die from smoking tobacco. What makes it even more challenging is the fact that many of these have not yet started to smoke! Can we help them to stay that way?

In spite of our many successes in reducing infectious diseases in Europe, AIDS now looms as an ominous threat for the years ahead.

These dangers have to do with individual behaviour and choice. Influencing people demands information, education and persuasion, so that every single individual joins the search for improvement. It also calls for political will and a substantial economic commitment because the defenders of people's health now have to rely on resources which are a small fraction of what is spent on the promotion of unhealthy life-styles.

New alliances for a new challenge

Today, WHO in Europe is building new alliances for health by networking with many new partners. This is a key to our success. The medical, nursing and other health professions, local and nongovernmental organizations, consumer groups, labour organizations, and industry have become natural counterparts in our intensified search for progress in health. For several years we have promoted research and development on the health problems related to affluent societies. This is an important part of our work with individual Member States, within the framework of the Regional Health-for-All policy. The following examples show where the emphasis lies today.

- Recently we have made vigorous efforts to provide practical, operational support to central and east European countries. We have also established specific country programmes with Member States so that WHO's work is guided to key health development efforts in countries, with perceived concrete outcomes.
- By joining the Healthy Cities movement (which was originated by this Regional Office), city councils have paved the way and shown that Health for All can only become a reality by involving the local authorities. They will be joined soon by schools, thus taking local action to a level which is even closer to the individual, and touches directly the Europeans of tomorrow.
- We also cooperate with industry. There is no doubt that the worksite will soon become one of the key grounds where the life-style and health issue is going to be won—or lost! To use this setting we seek the active support of both the labour unions and the companies.
- Another key area of development is *appropriate* care. Is it acceptable that in one country in Europe, a pregnant woman should have a four times higher risk of being submitted to surgical delivery than in an otherwise very similar country? Today's motto is appropriate care, rather than more care. We can help Member States, health professionals and industry to tackle these new issues and they can increase their dialogue with the population by collaborating with us.

Is all this a dream? Yes, but only to those with limited understanding and those who do not like—or dare—to open up new trails. But in WHO we have acted for many years as trail-blazers. Many approaches developed here have proved to be useful not only in Europe but to people in other parts of the world as well. You can help by joining us in the Health-for-All movement! ■

THE MEMBER STATES OF THE EUROPEAN REGION are:*

Albania	Ireland	San Marino
Austria	Israel	Spain
Belarus	Italy	Sweden
Belgium	Latvia	Switzerland
Bulgaria	Lithuania	Turkey
Czechoslovakia	Luxembourg	Ukraine
Denmark	Malta	USSR
Finland	Monaco	United Kingdom
France	Netherlands	Yugoslavia
Germany	Norway	
Greece	Poland	
Hungary	Portugal	*as of 11 December 1991
Iceland	Romania	

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READEX
FICHE

These young Europeans put all their enthusiasm into running a mini-marathon. They learn early in life what is good for their health.
Photo WHO/EURO/ H. E. Kristensen

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Towards Health for All in England

by William Waldegrave

As the United Kingdom's Secretary of State for Health, I believe there is no more important task facing me than developing a comprehensive strategy to improve the nation's health. Thanks to our health reforms, creating and implementing such a strategy is now a reality. The time is right to do so. We can now focus attention on maximizing health gains rather than on the day-to-day management issues of running our National Health Service.

The overall aim of the strategy for England (Wales, Scotland and Northern Ireland are developing their own, but similar, strategies) will be to improve the population's health, making the best and most efficient use of available resources. In doing so we seek to strike an effective balance between the three fundamental pillars of health: prevention, treatment and rehabilitation.

Our consultative paper *The Health of the Nation* reflects the principles laid down in Health for All. I was delighted that Dr Jo Asvall, Regional Director of WHO (Europe) gave such a warm endorsement to our approach. "This is", he said, "exactly what we would like every country to do."

The Health of the Nation sets targets for improving health. Target setting is an essential discipline for all those involved. Targets give us both something to aim at and a set of benchmarks against which we can measure progress. We will initially base the strategy around a small number of health priorities such as coronary heart disease and smoking-related cancers. In time we will add new areas, so building up a rolling process of health improvement.

Better health is a job for everybody, not just our health service. Individuals, employers, voluntary organizations, trade unions and others must all recognize their part in the strategy and respond. Through a shared commitment to better health lies the path to success. ■

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Health for All — theory and practice

by Justin Westhoff

Europe, summer 1991 ... In hot countries, the elderly are suffering badly from a heatwave. Because they live in certain areas, more elderly people are dying prematurely than elsewhere. In view of climatic, genetic and other factors that cannot be altered, how meaningful is WHO's slogan 'Health for All'?

Turkey, spring 1991 ... Kurds, maltreated for centuries, have fled from civil war in Iraq to find safety and compassion. In the refugee camps, children die every hour of the day from malnutrition and diarrhoeal diseases (which elsewhere would be easily controlled), the elderly die of weakness and young men and women from their wounds. The praiseworthy medical aid given by the international community appears to be merely a drop in the ocean. Health for All?

France, or Germany, or the United Kingdom ... A growing body of research findings show that immigrants are subject to considerably more health hazards than the nationals of those countries and have more obstructions to pass in order to gain access to the health care system. Equal health for all?

Berlin ... after unification of East and West. People in the former German Democratic Republic receive poorer medical care than those in the West, and in some cases the quality of care has worsened since unification. One example: following efforts by the health lobby to have health care privatized as far as possible and to close outpatient units and polyclinics, the number of diabetics suffering from diabetic coma has shot up in the eastern Länder. Even for a rich country in the heart of Europe, the same questions must be asked: Equality in health and life? Health for All?

Despite urgent questions like these, health care professionals and politicians in Germany (to judge by the situation in Berlin) mainly react positively when they are asked about WHO's slogan and its regional strategy to achieve "Health for All by the year 2000" in Europe. Where criticism is voiced, it is directed less at WHO and more at the lack of practical work towards WHO's targets in the European Member States.

The big question that faces health policy-makers in Europe: how to reduce inequalities in the struggle against sickness and death?

More research needed

Ingrid Stahmer, Senator for Social Affairs in re-unified Berlin, was previously Senator for Health (a senator is the equivalent of a minister in one of the German Länder). For her, Health for All means that problems of "social cooperation" and the conditions from which disease arise must be linked together. Not enough research has been done on social and psychological questions. Poor communication, stress at the workplace...too little attention has been paid to these and other issues. Medicine often pays only lip service to mental health.

She feels that WHO has taken the right approach: tackling the different social causes of disease in appropriate ways with different "prescriptions", and not "steamrollering a uniform concept across Europe". In this way, one country can learn from another: Ger-

mans, for instance, can acknowledge the value of social cohesion within the extended family in southern Europe, while others may value the relatively well-developed network of self-help groups in Germany. Innovations need not inevitably entail higher costs. Mrs Stahmer is particularly concerned about a number of issues: the widespread use of violence against children, a universal taboo in Europe; the lack of a lobby for the elderly; and inadequate social harmony between people of different origins. "Existential fears", she insists, "make people ill".

Anette Schwarzenau is municipal councillor for health in Charlottenburg, a large district of Berlin. She considers WHO's concept to be "inspiring". Charlottenburg is to join the Healthy Cities network. WHO's targets are of great help to her in persuading people who are conservative in health policy matters that health is more than "bandages and pills". The slogan Health for All has become a self-imposed obligation for urban districts such as her own.

One of the leading experts in prevention is Dr Rolf Rosenbrock, a sociologist and health researcher at the Berlin Science Centre. Both WHO's overall slogan and its regional strategy for Health for All in Europe contain a large number of "sensible thoughts", he says. He agrees that health promotion should not be a matter of professional policy alone, that all activities related to health must be coordinated with each other, that priorities must be set, and that prevention and cure must be seen as equally important.

But what is the real situation today? WHO has reported that in recent years inequalities with regard to disease and death have not been reduced, as had been recommended, but on the contrary have increased. Dr Rosenbrock blames this on the fact that little practical work towards WHO's targets has been done in Germany. Politicians like to give verbal support to WHO's formulations without really putting them into practice. In Germany, in particular, the health professions are too resistant. "There is no powerful health movement", he says, while acknowledging WHO's efforts to push forward the goal of Health for All by means of top-level congresses and meetings, some of which have been held in Germany. But the Organization is not in a position to intervene in its Member States' social and political deliberations, and this is precisely why a slogan is only as good as the determination and vigour expressed at national and local levels.

The spokeswoman for a professional medical association voices her thoughts forthrightly, almost with disapproval. "I get annoyed every year," she says, "when the latest slogan for World Health Day is proclaimed. It yields just as few results as the claim to Health for All, so long as it remains just something on paper!"

Involving the nurses

Senior nurse Jutta Beikirch looks at matters in a different way. She is now responsible for nursing personnel in the Berlin civil service. "WHO has helped us to get nurses more involved in health planning and reporting, even if they are not yet involved enough", she says. Nurses and care personnel are in much closer contact with patients, and community nurses in particular see the whole social and economic situation and know what "primary prevention and care" means. This is often more important than scientifically oriented medical interventions. WHO was right to point this out, and nurses can often make practical progress towards such targets more effectively than politicians or physicians.

However, Mrs Beikirch would like many of the Organization's arguments to be worded in "less abstract" terms since, she says, "my colleagues are practical people and have not yet learned much about dealing with abstract concepts". Moves towards a frontier-free Europe in 1992 must be carefully monitored, she warns. There are both opportunities and risks here. Health service workers can learn from each other and offer mutual support in their demands for better training, but this could also lead to a reduction to the "lowest common denominator".

Dr Ellis Huber, chairman of the Berlin Medical Association, considers that Health for All is justified as a "strategy for democratization". If you want more health, you must get away from "expertocracy". A far-sighted health policy has the task of creating healthy living conditions and fighting against inequity. The home environment, working environment, reformed medical and social services, more independence instead of dependence for people, more "health autonomy"—such calls by WHO are far more important than the introduction of more highly specialized medical technology.

"European thinking" must be pushed forward in this direction, says Dr Huber, and governments must be reminded of their duty to bring about, ultimately, "equity in health". If someone says to him that WHO's slogan is just a pious hope, he replies: "Only if you have the courage to dream do you have the strength to act". ■

INTRODUCTION TO THE WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR EUROPE

The World Health Organization's Constitution took effect on 7 April 1948. The Regional Office for Europe originated in January 1949 as the Special Office for Europe and was located in Geneva. In 1952 it became a Regional Office and was transferred to Copenhagen in 1957. It has some 270 permanent staff members from 44 countries (complemented by temporary consultants), who assist Member States with expertise and technical support.

In addition, more than 1000 experts and scientists are involved each year in WHO meetings in Europe, and many more are working for WHO in the 375 collaborating centres and research institutes in the European Region.

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Reforming outdated health systems

by Béatrice Majnoni d'Intignano

What is the best way of arriving at a compromise between equity and efficiency in health care? The countries of western Europe and Canada have reached this goal by principles of:

- Compulsory health insurance, with the State taking responsibility for the poorest people.
- Direct or indirect control of health expenditure by the State so as to ensure the right balance between costs and quality of care.
- Each individual contributing according to his or her means, but also paying for health care according to his own wealth.

This philosophy is radically different from that of the USA where—with the exception of the poorest and the elderly, who are covered by the Medicaid and Medicare systems—people are left to insure themselves, and where 35 million people are not covered at all despite the large amounts the nation spends on health.

In northern Europe—in such countries as Denmark, Sweden and the United Kingdom—the health systems stem from the Beveridge Report of 1942, drawn up by the founder of the British "Welfare State", Lord Beveridge. The principle of an individual "capitation" requires family doctors to filter access to specialized health care and to receive a per capita fee. This is not a salary, as many people believe, but consists of sums paid to the general physician according to the number of patients who inscribe themselves on his list and then receive health care free of charge. Other fixed sums are involved in this system, for instance to encourage doctors to work as a group practice, to practise in deprived areas, or perhaps to complete their training. Such activities as the first consultation, night visits, and contraceptive advice are paid for separately, and so are private consultations which the patients pay from their pockets.

In central Europe, particularly Germany, Austria and the Benelux countries, the health systems adopted may be called Bismarckian, after the 19th century German Chancellor, because they evolved from the first German laws on sickness insurance, passed in 1893. Health care here is financed from professional contributions, and is controlled by those who represent the insured individual. Medicine is available to all and is paid for according to the services used.

Physicians who are paid "a fee for service" work harder, devote more time to each of their patients and earn more because they tend to stimulate an increased demand for their services. As a result, in countries where surgeons are paid for their services, people have twice as many operations as people in countries where surgeons are paid a salary. As for technical interventions, these have sometimes become virtual money-making machines, as in the case of electrocardiograms or echography during pregnancy.

Payment according to the services has created a very active medical system oriented towards curative care rather than preventive action, based on the diagnostic, therapeutic, prognostic triad; its philosophy tends to be to take medical action rather than not to act. All the health systems in these "liberal" countries are at pains to make ever more precise diagnoses, even where truly effective treatments are lacking, and they still apply such treatments as they have, particularly when they are dealing with people of very advanced age.

Countries of the east

The countries of eastern Europe have their own national health systems, but a certain malaise has crept in because the doctors are officials of the State. They work less than doctors in western countries, and are more ready to sign sickness notes for their patients or order them to hospital. By giving their doctors a salary but only a low one, and by treating them as heirs of the bourgeois classes and therefore non-productive personnel, these countries have sapped them of motivation.

Health care is in principle free, but pharmaceuticals are practically unavailable. Owing to shortages of contraceptive pills in most polyclinics, abortions have become more frequent than births. Sickness notes to give people time off work, as well as the services of the few really competent surgeons, are paid for "under the table". In the USSR, it appears that legal health cooperatives represent 3-4% of the expenditure on health care, but the kickbacks could amount to eight to ten times more.

The eastern countries only devote a tiny part of their gross national product to health: 3% in the USSR and 2.5% in Romania, compared to 7.5% in the countries of the Organization for Economic Cooperation and Development and 12% in the USA. As a consequence, medicine has come to be equated with "inequality and inefficacity", and the attempt made by the USSR in 1985 to improve the situation by increasing the doctors' salaries by 30% ended in failure.

Everybody ought to have access to medical services, whatever method is chosen for financing health care.

Photo: WHO/J. Mohr

The demographic indicators testify to the scale of the disaster. Expectation of life in USSR, Czechoslovakia and Hungary, which used to be comparable with that of the western countries in 1970, is today some *five to eight years* less. In Romania, infant mortality ranges, from one area to another, from 17 to 50 per 1000 live births, compared to 7 in France.

Health in the time of perestroika

It will take decades to put this situation right, and medicine as a whole will have to be reorganized with the support of a healthy economy.

From 1988 onwards, the USSR chose to introduce an experiment in free market mechanics and financial incentives into the national health system, which it wants to preserve. The polyclinics in St Petersburg (formerly Leningrad) will henceforth receive an identical per capita fee (75 to 100 roubles) for each citizen in the zone which they serve, and from this they have to deliver health care free of charge, either directly or by paying for hospital services. The hospitals no longer receive a budget but rather an advance payment, and they then have to sell their services according to a fixed tariff: 17 roubles for an abortion, 550 roubles for orthopaedic surgery and so forth. In certain cases where treatment fails, the patient may be taken into the hospital again without having to pay a second fee.

The benefits of the new system are already being felt. The length of stay in hospitals has fallen, in St Petersburg dropping from 17 days to 12 days in the space of a year. The polyclinics seem to be accepting more responsibility and are obtaining equipment so that they can undertake minor surgery. The Fiodorov eye surgery centres are even going so far as to pay their surgeons "for each eye cured"—hoping in this way to reduce the numbers of failed operations and infections.

The other countries of eastern Europe have adopted a different approach. The doctors there are often agents for change themselves. Fascinated by American liberalism in medicine, they have rejected the national system and cheerfully confuse the effects of liberal mechanisms with that of the wealth of the western clientele. The World Bank and WHO have sounded a warning that universal access to health care and controlled budgets are put at risk because of the wish to get rid of bureaucracy and mediocrity.

The financing of health cannot be reformed without fiscal and salary reforms. The real question is to know whether it is best to continue paying fixed salaries, subject to the arbitrary ways of state bureaucracy, or to step up salaries in the health sector and create sickness insurance schemes so as to engage the general public in a process of responsibility, individual choice and democratic control of health expenditure. How otherwise can the present system of kickbacks be turned into a legal one, and how can doctors be persuaded that other forms of payment would be more ethical?

The health systems of eastern Europe do not need to fall into the same traps as those in the West, which were conceived at the end of the 19th century or after the Second World War. Perhaps they will avoid the pitfall of certain professional health insurance schemes, where the ratio between the number of contributors and the number of beneficiaries can sometimes be catastrophic, and will instead prefer freely chosen health insurance options.

By contrast, the example of the West ought to encourage them to prefer the European philosophy to that of the USA, to experiment with per capita fees for their family doctors, to ensure that their insurance schemes and their doctors have more responsible representatives than trade union officials, and to use payment mechanisms better adapted to their true objectives—namely equity, full employment, and doctors' social status. The new philosophy of being able to shop around for the best available health insurance, public as well as private, ought to interest them as a first priority.

Recent experiences in Europe have confirmed that it is financial incentives that shape the behaviour of doctors—hence the interest in choosing those incentives well. ■

Eurohealth: a project for eastern Europe

Europe is at present undergoing profound and, in some cases, drastic changes. Political, economic, social—no sector is spared. The health sector in Europe had already been under criticism—partly because it was becoming too expensive, partly because of inefficiency. People were becoming disenchanted. In some overly centralized and bureaucratic systems there was little room for public participation—just at a time when people were becoming more and more aware of the importance of health and more and more eager to take responsibility for their own health.

The Eurohealth project was developed to contribute to the health care debate of the 1990s in Europe and more specifically to cater to the needs of the countries of central and eastern Europe, where the debate about the future of their health care systems is particularly lively.

The aim is to collaborate with countries in developing new and more appropriate health policies, to promote innovative action in local communities, and to improve the organization, management and financing of health care. The project also seeks to improve the health information systems and the training of health workers. Research into ways of improving the situation is also regarded as an urgent priority.

Contributed by Dr Constantino Sakellarides, Director, Division of Health Services, WHO Regional Office for Europe, Copenhagen.

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Environment and health — everyone's concern

by Elaine C. Grandjean

Global warming, acid rain, urban smog, polluted beaches, nitrates in drinking water, salmonella poisoning—these are but a few of the environmental problems that make daily headlines. In particular, the countries of central and eastern Europe face a steep uphill battle to reverse environmental degradation and to balance "progress" against protecting human health and the environment.

Throughout Europe, there is a common resolve not to repeat the mistakes of the past: the accidental release of dioxin at Seveso, Italy, which caused chloracne and other health problems in several hundred residents; the toxic oil syndrome in Spain, which killed hundreds and made many thousands chronically ill; and the nuclear power accident at Chernobyl in the Soviet Union, necessitating the relocation of hundreds of thousands of people and evoking the long-term spectre of increased numbers of cancers.

Certainly Europeans are fully aware that "health" and "environment" are not separate concerns but are tightly linked—for better or for worse. They recognize that their environment encompasses all the physical, psychological, social and aesthetic elements that are conducive to health, such as safe drinking water and food, well-planned housing, noise control, clean bathing water and green spaces in the cities. Powerful forces for change, such as the press, consumer activism, and the lowering of political and trade barriers, have sharpened this awareness. And Europeans are showing a willingness to work together towards making the link between health and environment a positive one.

Political commitment is trying hard to keep pace with this popular movement. It was against this backdrop that, on 8 December 1989, 29 European countries endorsed the European Charter on Environment and Health. This landmark event took place during the First European Conference on Environment and Health in Frankfurt, Germany. There, ministers of environment and health put aside their sectoral differences in favour of a common goal: safeguarding human health by safeguarding the environment. By this act, the countries of Europe unanimously agreed to follow up a range of urgent environment and health issues—and to take action *now*.

In recognition of the importance and relevance of the Charter, the Commission of the European Communities also adopted the Charter as a guideline for future work.

A framework for change

The Charter touches every level of society in one way or another, from the individual to international organizations. Above all, it stresses the shared responsibility of everyone to safeguard the environment, to ensure adequate and accurate information, and to be involved in decision-making. In particular, the media must play a key role in promoting awareness and a positive attitude towards protecting health and the environment.

Fourteen principles for public policy support the Charter. Among them are the axioms that prevention is better than cure, that the polluter should pay, and that human health takes priority over economic considerations. The environment is seen as a resource for improving living conditions and increasing well-being.

The Charter outlines what needs to be done to put these principles into action, whether through improved technology, legislation, education or training. Strong information systems

Priority environmental health issues include:

- global disturbances to the environment
- urban development, planning and renewal
- safe and adequate drinking-water supplies; hygienic waste disposal
- quality of surface, ground, coastal and recreational waters
- safe food
- environment and health impact of energy options, transport and agricultural practices
- ambient air quality (oxides of sulfur and nitrogen, photochemical oxidants and volatile organic compounds)
- indoor air quality
- persistent chemicals and those causing chronic effects
- hazardous wastes
- biotechnology
- contingency planning for and in response to accidents and disasters
- cleaner technologies

Photo WHO Zafar

Green spaces are the "lungs" of the city—essential organs for the good quality of urban life.

Photo WHO/T. Farkas

Taking noise measurements in the centre of Athens.

must play a vital role in this strategy by helping to monitor the effectiveness of the measures taken on the basis of priorities set and of decisions made. It calls on countries to take all necessary action to reverse negative trends as soon as possible, and to work with each other and intergovernmental groups to tackle pollution problems that recognize no national borders.

The Charter is only a means to an end; it is a framework, not a blueprint, for change. The blueprints are now being drawn up by the countries of Europe, each according to its needs and resources. Only then can the Charter have real meaning. Already more than 20 countries are working to make it come alive. As a basic step, the Charter has been translated into 17 languages. Regional workshops and seminars are bringing together countries to share ideas and know-how. Spain, for example, convoked the chief medical officers and directors of environment from all 17 provinces to create a policy for putting the Charter into action in all sectors, including energy, transport and trade. The United Kingdom has made the Charter a key element in the government's newly developed proposals for a health strategy.

The Charter called for a European Centre for Environment and Health to be set up, and the governments of Italy and the Netherlands promptly stepped forward with resources and facilities. The Centre has operational units in Rome and Bilthoven.

With an initial staff of 26, the Centre forms part of the Division of Environment and Health of the WHO Regional Office for Europe. Its first priority is to prepare a comprehensive report on environment and health in Europe called "Concern for Europe's Tomorrow". Information from many sources is being collected and analysed to find out the status of environment and health in each country of Europe, as well as to forecast changes over the next 10 to 20 years. On the basis of the report, a longer-term programme, tailor-made for the countries of Europe, will be developed.

The Centre's staff help countries in Europe on practical matters regarding air and water pollution, food safety, radiation protection, environmental epidemiology, toxicology, and information system management and operations. Its studies include a long-term follow-up of the health of people affected by the Chernobyl nuclear accident in 1986, the strengthening of surveillance systems for foodborne diseases, and the development of an integrated approach for assessing and reducing human exposure to contaminants in air, water and food. The Centre has also begun a US$ 3 million project to help Czechoslovakia, Hungary and Poland to put the Charter into effect. ■

Mrs Elaine C. Grandjean is an information specialist with the Division of Environment and Health, WHO Regional Office for Europe, Copenhagen.

Heartbeat Wales

by John C. Catford

Our health depends on more than just life-style behaviours, it is encouraged—or damaged—by the psychological, physical and social factors which together make up our environment. The best intentions and the strongest commitments can hit obstacles on the road to health. We may want to cycle to work, but we may not have cycle pathways to make cycling safe as well as healthy. We may try to reduce fat in our diet, but find it difficult when supermarkets don't sell low fat foods, or don't label food clearly.

Environments that encourage and support us in reaching health targets can be created; conditions that inhibit high levels of health can be changed. In Wales, our aim is to make the healthy option the easy option—by working with retail shopkeepers so as to encourage easy access to healthy foods, by providing exercise tracks and trails, by working with local government on planning issues, and by involving employers in the health of their work force.

Over the last 50 years, Europe has witnessed epidemic levels of chronic diseases such as cancer and coronary heart disease. These in turn are closely related to life-style, such as smoking, drinking and overeating. Life-styles in Europe vary greatly. The French love good wine, and this results in a high level of alcohol consumption—twice as much per person per year as in the United Kingdom. The Dutch get plenty of regular exercise as they use bikes, not cars, for most short trips, and have planned their roads and cities to make riding bicycles safe and convenient. In Greece, more cigarettes are smoked than in most other European countries—five times as many as in Norway. Some countries in eastern and central Europe are showing increasing levels of cigarette consumption while others, such as the United Kingdom, are showing a decline. These patterns of disease and life-styles in Europe show where we need to concentrate efforts in progressing towards health targets for the region.

Life-style behaviours are established at a very early age, but they can be changed with consequent benefits to health. Stopping smoking, eating a balanced diet, taking regular exercise, drinking sensibly, all these reduce the risk of a range of chronic diseases. Given the right kind of information, skills and encouragement, individuals and whole populations can adopt new behaviours and change to healthier life-styles.

Coronary heart disease is a major killer in Europe, and many of the risk factors linked to the disease are associated with life-style. Levels of the disease vary greatly across Europe, and are particularly high in the United Kingdom. In Wales, heart attacks claim the lives of one in four men and one in eight women before their 75th birthday. "Heartbeat Wales", a community-based intervention programme, set out to meet this challenge and to put the health of Wales on course with the best in Europe, by tackling the problem among the population as a whole, not just those at high risk.

Three risk factors

Launched in 1985, Heartbeat Wales focused on the three most important risk factors for heart disease that are open to change:

- raised blood cholesterol
- raised blood pressure
- smoking.

It aimed to reach all levels of society—individuals and the community; education; business and industry; government and the health sector. Full use of the press, radio and television helped to draw attention to the programme in its early days.

Because it was seen as a demonstration programme for other parts of Europe, it has been particularly well documented, with periodic evaluation to gauge the progress and show where more effort is needed. The programme was designed and carried out in partnership with the people of Wales. From the beginning it was realized that, to be effective, simply "dropping leaflets from airplanes" wasn't going to work. Heartbeat had to belong to the community. In the planning stage,

Photo WHO/Heath Promotion Authority for Wales/D. Stephens

In response to public demand, the food industry is producing low-fat products for general consumption.

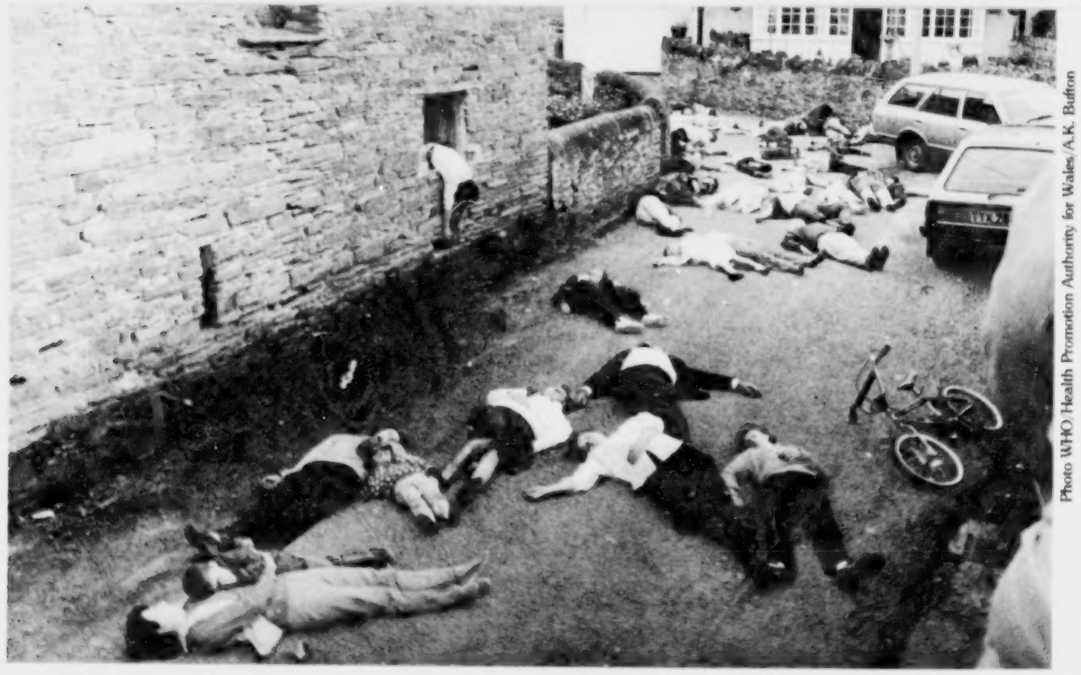

Photo WHO Health Promotion Authority for Wales/A.K. Button

New-style pyscho-drama: an entire Welsh village "dropped dead" one morning in 1987 to dramatize the slaughter represented by cardiovascular diseases.

people were invited to share their views and contribute their ideas, and these were later used in designing the various intervention components.

The support of the food industry itself was canvassed to ensure that healthy foods were not only available in the high street, but were also competitively priced.

One area of concern was overweight among the Welsh people, since the programme's own survey showed that as many as 50% of the population were too fat, to the point where their health was affected. Overweight is associated with a wide range of health problems ranging from diabetes to coronary heart disease. Losing weight, usually through a combination of dietary modification and increasing physical exercise, will reduce the risks. The "Lose Weight Wales" campaign was designed to raise public awareness of the problem and to encourage and support individuals and groups in doing something about it. Lose Weight Wales is working with Women's Institutes on a major weight-loss competition ending in September 1992; this offers an incentive to adopt a healthier life-style and healthy eating habits permanently.

Today, five years after the programme began, the community is still very much involved and is building on the success of Heartbeat Wales. The parent body, the Health Promotion Authority for Wales, has launched further initiatives to promote good health as part of its "Health for All in Wales" strategy.

"Good Health Wales" addresses a range of health issues for adults, such as healthy sexuality and preventing HIV infection. The "Make Health Your Business" Award encourages the business community to create working environments that support people in being healthy. Absenteeism from work is high in Wales compared to other parts of Europe, so ill health is very expensive. For every working day lost through strikes, more than 30 are lost through absence because of ill health. More than 500 businesses have declared their commitment to the "Health for All in Wales" strategy and have made provision for health screening, exercise, family welfare, nonsmoking policies and healthier canteens.

Unhealthy pressures

Young people's contribution is channelled through the new "Youth Life Wales" initiative. A 1990 survey showed that nearly half of Wales' 15- and 16-year-olds drank alcohol at least once a week, even though it is illegal to sell alcohol to children under the age of 18. A number of new schemes have been developed to tackle this, including mobile education units called Life Education Centres which visit schools. These centres seek to teach children the skills to resist peer pressure—to "immunize" them against unhealthy pressures from adults, advertising and society in general.

There are encouraging signs of improvement in life-styles, and the results of regular surveys show that Heartbeat Wales and the health promotion activities of the Health Promotion Authority for Wales are indeed working. Between 1985 and 1986, the percentage of smokers in the Principality fell by 4% for men and 3% for women—a sharper fall in the number of smokers in Wales than in any other part of the United Kingdom. The rise in overweight and obesity levels at last seems to be levelling and beginning to fall. There is also a growing trend towards healthier eating, with people opting for more fruit and vegetables and cutting down on foods high in saturated fats. More people are active, with almost half of the men and one quarter of the women exercising at least twice a week.

Heartbeat Wales has helped people to make healthy changes in their life-style. It has put the heart back into Wales, adding life to years and years to life. ■

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Photo WHO/M. Jacot

The clock can't be stopped

by Hana Hermanova

In 1960 the proportion of people in Europe aged 60 or over was 14%; by 1980 it had risen to 17%, and by 2025 it is expected to be 25%. Meanwhile, fewer and fewer family members are available to care for the elderly. The best solution to this problem would be to create conditions allowing the elderly to remain healthy so that they could look after themselves.

At present, Sweden has the highest proportion of elderly people in Europe; by the year 2000, however, the highest proportions will be in Germany and Greece; 25 years later this distinction will be shared by Germany, Luxembourg, the Netherlands and Switzerland. The fastest projected rate of population growth for elderly people, however, will be the USSR, where the number of those aged 60 or over will have risen from 35 million in 1980 to 72 million in 2025.

Problems brought by success

These developments, which reflect a general increase in life expectancy since the Second World War, produce new challenges that we must address if crucial problems are to be avoided.

The number of people aged 80 or more is rising particularly rapidly. These people consume a greater proportion of health care and social services than any other age group. Because women live longer than men on average, the socioeconomic and health problems of elderly people are largely borne by women. As more women enter the job market, there are fewer of them available to care for elderly people than formerly. This factor, together with increased migration by young people, is weakening family and community support and protection for the elderly.

Why is the life expectancy of men less than that of women? Why do some people lose their ability to function while others remain active and productive? What changes should be made in life-styles and behaviours to maintain our vital potential and autonomy? Most such queries are still unanswered, but it is now widely accepted that progress can be made only through the search for *healthy aging*, which was first discussed in 1990 by WHO's Regional Committee for Europe.

Old age is not a disease and cannot be prevented! The occurrence of chronic, degenerative diseases in old people can, however, be diminished, though not by means of curative medicine alone: middle-aged people should be the main target for health promotion, with a view to preventing disability in old age. It should also be noted that there are differences between European countries in life expectancy and morbidity and disability rates.

It is to be expected that the health and functional ability of people aged under 75 will improve and that they will look for better opportunities to remain active in society. At the same time, governments are likely to be seeking a balance between early retirement (to ease the job market) and late retirement (to reduce the cost of pensions). Meanwhile, a large increase in the proportion of people aged 85 or over can be expected to

Plenty of daily activity helps the elderly to stay healthy.

create a growing demand for personal care and help with the tasks of daily life.

Who will look after the very old?

In most European countries it seems probable that community-based care, and home care in particular, will provide the best solution to the problem of looking after the elderly. But as relatives and neighbours are likely to become decreasingly available as carers, it is important to consider who might replace them. Of course, institutional care will remain necessary for some people, among them those who are severely disabled or live alone.

A balance has to be struck between the provision of community services for home care and the provision of institutional care. Rehabilitative facilities will have to be increasingly relied on to develop and maintain the functional ability of elderly people so that they can live as independently as possible. Changes in attitudes will have to be encouraged among health and allied professionals and the general public. Human and financial resources should be redistributed and people should become more closely involved in the development of medical ethics and play an active part in the choice of care and the protection of their own health. ■

Dr Hana Hermanova is Regional Adviser on the Elderly, Disability and Rehabilitation, WHO Regional Office for Europe, Copenhagen.

Cities on the road to health

by Flemming Holm

Public awareness of the need for health development has increased greatly in Horsens, Denmark, since the city became part of a European project entitled "Healthy Cities—by the year 2000".

Although situated in a rich part of the world, Horsens certainly has its problems. Alcohol and drug abuse is a daily reality for the 5 full-time and 35 voluntary staff who keep the Healthy City project of Horsens running. Failures in industry and businesses, unemployment, and resulting loss of income for a large part of the population have put the municipality in constant need of funds. Financial hardship goes back to the Wall Street crash in 1929, since when the municipality has never been able to make ends meet. As a result, the city has been under central government administration for decades. Although it has now recovered financial autonomy there are families receiving socioeconomic aid for four generations! This means that the young people from these families get their money from the social security office. They have given up from the beginning, because that is what they saw their parents do. And they did it, because that was the solution their grand-parents showed them.

The small town of Horsens in Denmark forms part of Europe's Healthy Cities project.

The situation began changing in 1987, when Horsens, which has 55 000 inhabitants, joined the European Healthy Cities project. Since then, great progress has been made in disease prevention and health promotion. The municipality's 5000 employees are now much more aware than formerly of the health implications of their actions and decisions. This applies to town planners, social workers, teachers, refuse collectors and many others. WHO recommendations will be implemented throughout the municipality over the next few years. This would not have happened if the start-up period had not been a visible and solid success.

In 1990 a WHO study found that Horsens was performing better than the 29 other participating cities in respect of seven health-related criteria: political support, visibility, structure and process with leadership and direction, action for health, intersectoral action, community participation, and resources. For an eighth criterion,

The Healthy Cities project

The project embraces a network of European cities that experiment with new ways of promoting health and improving the environment. The goal is to turn a vision of healthy cities into reality through political commitment, the shaping of ideas and experiences, innovative action and institutional change.

As has been said by Dr Jo E. Asvall, Director of the WHO Regional Office for Europe, we already know what the problems are and much about how to solve them. A political will for action has to be created: the challenge is to deploy the managerial skill and innovation required to pull together the vast human and other resources that cities possess and to bring them to bear on this work.

Photo: WHO Horsens Tourist Office

Photo WHO Gwynedd Health Authority

A bar serving alcohol-free drinks is a popular rendezvous for youngsters in Gwynedd, North Wales; a healthy life doesn't mean you have to be miserable!

equity. Horsens was adjudged to be inferior; this, of course, is a matter of taking initiatives that can close the gap between the deprived and the affluent.

The people are being shown that change depends on themselves and on their community participation in recovery from social and ecological breakdown. People are rediscovering purpose and dignity as they begin taking care of their neighbourhood, in small but valuable daily actions.

Some project cities

Austria	Israel
Vienna	Jerusalem
Belgium	Italy
Liège	Milan
Bulgaria	Padua
Sofia	Lithuania
Denmark	Kaunas
Copenhagen	Netherlands
Horsens	Eindhoven
Finland	Rotterdam
Turku	Spain
France	Barcelona
Montpellier	Seville
Nancy	Sweden
Rennes	Gothenburg
Germany	Stockholm
Bremen	United Kingdom
Düsseldorf	Belfast
Frankfurt	Bloomsbury
Munich	Camden
Greece	Glasgow
Patras	Liverpool
Hungary	USSR
Pécs	St Petersburg
Ireland	Yugoslavia
Dublin	Zagreb

Another important development has been the bringing together of different services in the interest of health, in what is known as intersectoral collaboration. Both the education department and environmental department cooperated in such a way that schoolchildren became involved in the disposal of domestic waste materials, such as chemicals, paints and solvents. This has helped to demonstrate to young people the practical significance of ecology teaching. Furthermore, the children tend to influence their parents in favour of healthy housekeeping. The environmental department thereby saves energy and resources, and pollution is reduced. Easy? Yes, in a way, but someone has to bring the two departments together. In Horsens it was the Healthy City project.

At present there are some 60 collaborative schemes in the city, including instances of cooperation between the public and private sectors. In fact the private sector is now happy to invest money in health promotion. Recently, a private consultancy, the Horsens Health and Environment Group, was set up by the municipality with a view to exporting advice and know-how.

The city is also using what it calls action-oriented health communication, a way of reaching out to people without adding unnecessarily to their already excessive burden of information. A Healthy City Shop has been established with exhibitions, workshops, telephones, fax and other facilities. The aim is to provide help for all who visit the shop. Self-help groups have been formed and some 70 other health-promoting activities have been undertaken.

Thank you, WHO, for the inspiration! And please take these ideas to all the other cities in the world where people are suffering urban deprivation. ■

Qualities of a healthy city

- A clean, safe physical environment (including housing)
- A stable, sustainable ecosystem
- A strong, mutually supportive, non-exploitative community
- A high degree of participation and control by the public over decisions affecting their lives
- The meeting of basic needs (food, water, shelter, income, safety, work) for all inhabitants
- Access to a wide variety of experiences and resources, with opportunities for diverse contacts, interactions and communication
- A diverse, vital and innovative economy
- Encouragement of connections with the past, with the cultural and biological heritage, and with other groups and individuals
- A form compatible with and enhancing the preceding characteristics
- An optimum level of appropriate public health and sickness care services accessible to all
- High health status

Mr Flemming Holm is a journalist in Denmark. His address is Healthy Cities Project, Rådhustorvet 23, 8700 Horsens, Denmark.

Health targets for Eu

Smoke-free Olympics, Barcelona 1992, a step towards a smokeless society

A healthy, well-balanced diet is essential for physical and mental well-being.

In 1977, WHO's Member States resolved that by the year 2000 people everywhere should have access to health services enabling them to lead socially and economically productive lives. The European Member States adopted a regional strategy in 1984. It contains 38 targets that must be reached to make the dream of HEALTH FOR ALL (HFA) BY THE YEAR 2000 a reality in Europe.

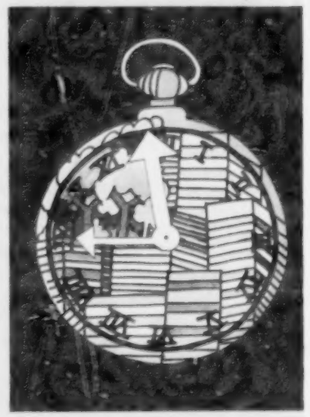
They enable us to assess whether politicians, health authorities and health professionals support HFA. They tell us whether all sectors in society, such as agriculture and education, are working for better health. They measure whether we all, as individuals, support it. All European countries agreed to follow the plan of action, without, of course, being obliged to follow it precisely. Each country will develop a strategy based on its own specific problems and possibilities.

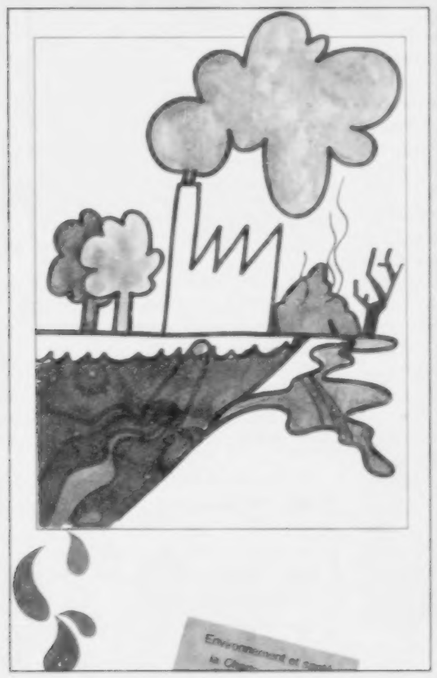
The targets are about equity in health, adding life to years, adding health to life and adding years to life; about healthy life-styles, healthy environment and appropriate care; and about research, health policies, education, and appropriate technology.

What is your country doing to reach these targets?

Exercise is good—but not just anywhere. A polluted atmosphere will hamper the benefits. ▶

Time is ticking away. Quick action is needed, if we are to achieve a healthier environment. ▼



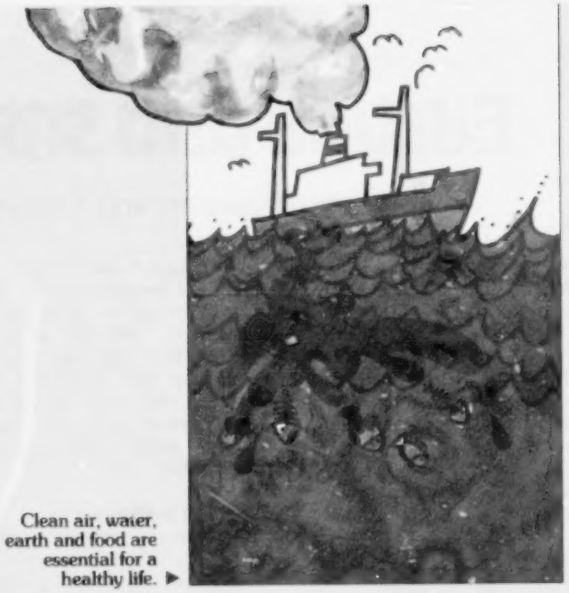


A cleaner environment, appropriate health services and active leisure time will help us achieve a healthier life. ▶

◀◀ **Our health is threatened by a polluted environment. The struggle for a cleaner planet must go on.**

◀ **The goal of Health for All is our common responsibility. We have to work together to achieve it.**

rope ...



Clean air, water, earth and food are essential for a healthy life. ▶

▲
A major task for the 1990s will be to find ways to prevent and better manage natural and man-made disasters.

The quality of health care is very ▶ important: merely providing care is not enough.

Europe and smoking

by Marc Danzon and Tapani Piha

In the fight against smoking undertaken during the last few decades in European countries, not only the protection of people's health is at stake, but also the future credibility of health promotion measures. In this continent, smoking is responsible for 1 200 000 deaths each year, a figure which makes it the biggest avoidable risk factor. Yet despite the vast scale of the problem, the protectors of public health are confronted by lobby groups representing those who profit from the epidemic. The success or failure of this fight will decide the future of preventive measures and health promotion, and perhaps even the future of health policies. Success would silence those who doubt the real effectiveness of well-planned and determined programmes aimed at reducing the risk factors; failure, on the other hand, would mean that public health has very little influence by comparison with powerful lobbies.

Over the last 20 years, European countries have taken various measures to combat smoking. Many of them have launched information and education campaigns; others have passed legislation aimed at limiting or even eliminating tobacco advertising and protecting nonsmokers in public places; yet others have concentrated on making cigarettes very expensive, though usually for economic rather than health reasons. Serious and long-lasting measures have certainly had positive effects but, even in the best of circumstances, these positive effects have been slow to emerge. In any event, few countries apart from Finland and Iceland have pursued complete and consistent policies in this area.

During the last four to five years, however, the fight against smoking in Europe seems to have changed in nature, and has acquired a force, energy and rationality that it did not have before. The WHO Regional Office for Europe has played an important role in this change by defining the fundamental criteria which should guide all anti-smoking policies and by securing their adoption. Stated briefly, success depends on attacking tobacco simultaneously on every front, making full use of all sectors and all professions capable of providing support in this fight. Accordingly, an action plan was adopted in 1987 by all the countries of the European Region, and at a conference held in Madrid in 1988 a charter was drawn up which laid down certain principles and recommended strategies for putting this action plan into effect.

Anti-smoking policies

Despite vigorous opposition, the Commission of the European Communities has developed a very active policy since 1987 which seeks to amend legislation in the 12 Member States, particularly as regards lower tar content, health warnings on packaging, and restrictions on advertising.

At the national level, the introduction of anti-smoking policies has been given a boost by these international commitments. Today, Europe can be divided into three:

– One third of countries have vigorous policies. The French Parliament, for example, recently passed an innovative law prohibiting all promotion of tobacco products and increasing cigarette prices. Passing such a law proved difficult because of opposing interests, but the determination of the protectors of health finally won the day, providing a positive example that other countries might like to follow.

– In the second group of countries, the policies are more recent, but the pace of action has speeded up considerably over the last few years. Some eastern European countries such as Poland are in this group.

– Finally, the third group is still not taking determined action. They include some countries where tobacco is grown and processed, and where the tobacco industry has close ties with the public sector.

The countries of central and eastern Europe face a special challenge. Public places and public transport have long been the preserve of nonsmokers, and cigarette advertising used to be prohibited (though not for health reasons). Yet preventive measures were poorly funded and received little support from public opinion. The tobacco industry of western Europe now sees these coun-

Smoking is no recipe for happiness and can ruin your health.

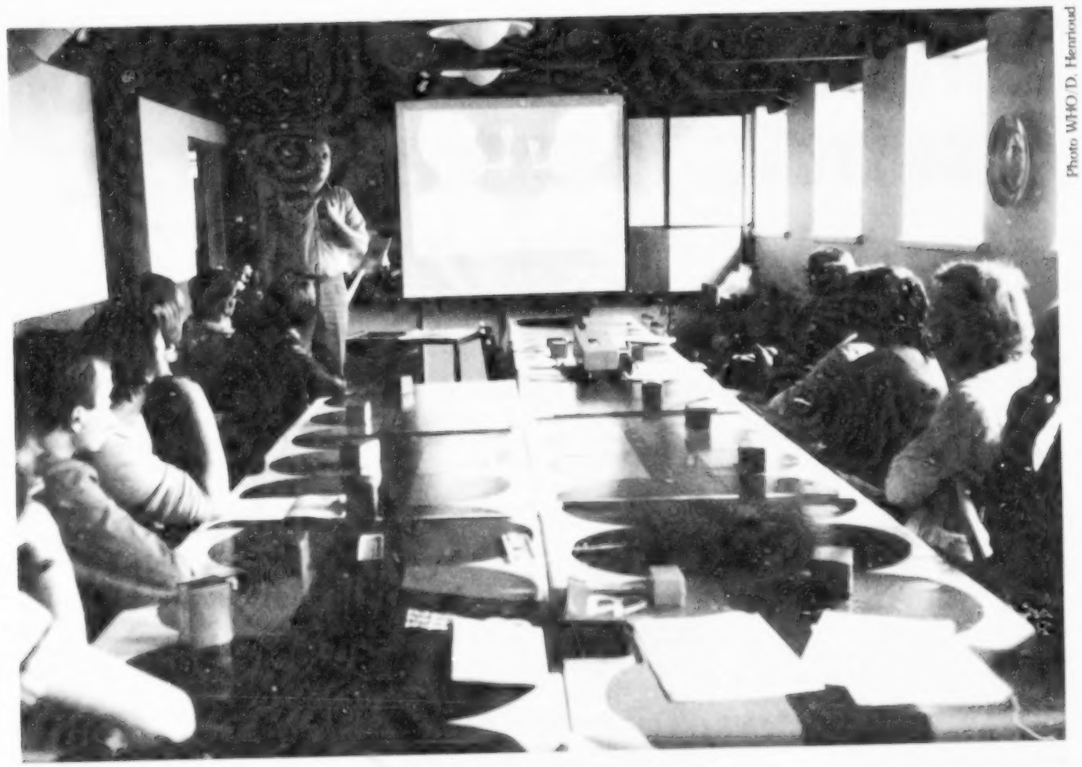


Photo WHO D. Henrioud

Anti-smoking education in North Karelia, Finland.

ANTI-SMOKING CHARTER

The right to breathe clean air without tobacco smoke is an integral part of the right to live in a clean and non-polluted environment.

Every citizen has the right to be informed about the high risks that tobacco has on health.

Every child and adolescent has the right to be protected from all forms of tobacco promotion, and to be given every assistance, whether by educational or other measures, to resist the temptation of starting to use tobacco in whatever form.

Every citizen has the right to breathe air in enclosed public places and public transport, which is not polluted by tobacco smoke.

Every worker has the right to breathe air at the workplace which has not been polluted by tobacco smoke.

Every smoker has the right to be encouraged and helped in order to give up the habit.

tries as a major market to conquer, and this could bring about an increase in smoking, particularly among young people and women. In order to prevent this, it is essential to make the ordinary people and opinion leaders really understand that in Western countries, which they often take as a model, the tendency today is towards *nonsmoking* and *promoting a smoke-free environment*.

It is still too early to assess what beneficial effects on mortality and morbidity have been produced by the fight against smoking. Certainly there have been some behavioural changes in countries which have pursued a continuous and determined policy. In those countries there are fewer male smokers than there were in previous decades.

Women smokers

Women are the prime target for cigarette advertising. In countries where traditionally few women smoked, there are now more female smokers than in the past. However, the most recent statistics show a decline in countries such as Denmark and the United Kingdom where there have been many women smokers for a long time.

Signs of a decline in the number of young people who smoke or who are starting to smoke in some countries are the most encouraging result.

Clearly the fight will be long and arduous. Whatever the result, it will be a landmark in health promotion. The tobacco lobbies will use any means to defend their profits, as they recently proved in France by trying in vain to halt a poster campaign which humorously pointed out the lies used in advertising to promote brands of cigarettes. The tobacco industry goes even further, and is making up for losses incurred in developed countries by investing in developing countries. It has no hesitation in adding to their existing problems by destabilizing the economy, agriculture, and slender family incomes.

It follows that, as in many other areas, solidarity and collaboration at a global level are essential for the fight against smoking, and against risk factors in general which endanger public health. ■

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Eurohealth: a programme for central and eastern Europe

by Jacques A. Bury

In 1980, when WHO's European Member States adopted the Regional strategy for "Health for All by the Year 2000", they agreed that their first aim should be a higher level of equity—a reduction of inequities both within and between countries in Europe. This endeavour is as relevant in the early 1990s as it was in 1980, and it is the foundation for the Special Programme of Cooperation with Countries of Central and Eastern Europe, launched by the WHO Regional Office for Europe in September 1990.

Equity does not mean that everyone should have the same health status, or use the same amount of health service resources irrespective of need. Some people might dismiss equity as a goal altogether if they interpreted it along such lines. Solving problems of inequity cannot be achieved by one level of organization or one sector, but has to take place at all levels and involve everyone as partners in health to meet the challenges of the future. Equity in health implies that, ideally, everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be hindered from achieving this potential.

Equity in health is not egalitarianism. It is a fair chance for all. We have considerable evidence in Europe that this apparently obvious aim is in many cases far from being within reach of all. Disadvantaged groups have poorer survival chances and die at a younger age than more favoured people. A child born to professional parents in the United Kingdom can expect to live five years longer than a child born into an unskilled manual household. In Hungary, males living in the most depressed neighbourhoods have a life expectancy about four years less than the national average, and five and a half years less than those living in the most fashionable residential district.

Disadvantaged groups do not only suffer a heavier burden of illness than others, but also experience the onset of chronic illness and disability at younger ages. Individuals are confronted with all sorts of barriers in their quest for health. Transport costs fall most heavily on low-income groups, limiting their access to services, even though these are theoretically available; clinics may have inconvenient opening hours so that only limited groups of people can make use of their services; ethnic minorities may find language and cultural barriers to be major obstacles.

Photo WHO, M. Gombeaud

The new leaders of Albania, together with the international community, are working to reconstruct the country's health infrastructure.

Political options also play a prominent role in this respect. For example, rehabilitation services are scarce in many countries; they often concentrate on getting people back to work and so are biased in favour of people with jobs, and against the unemployed, retired people and housewives. The quality of care may be compromised by the poor quality of premises in disadvantaged areas, where experienced staff may be reluctant to work. Proposed solutions to economic problems often involve restricting government expenditure in the social sector, and the disadvantaged are again hardest hit as a result. It is part of WHO's mandate to remind politicians and decision-makers that health is wealth; that money spent on infrastructure and training is an investment, and not merely an "expenditure".

Profound and rapid changes in the political situation of several countries in central and eastern Europe have prompted the emergence of new needs, and the identification of new priorities. In September 1990, the Regional Committee—in other words the governments of WHO's European Region—requested the Regional Director to develop a programme of intensified cooperation with those target countries, namely Bulgaria, Czechoslovakia, Hungary, Poland, Romania, the USSR and Yugoslavia. It can be foreseen that Albania will join the programme soon.

Health trends in those countries from 1960 to the late 1980s had been very unfavourable compared to the rest of Europe, particularly as regards life expectancy at birth, infant mortality, mortality due to circulatory, cerebrovascular and ischaemic heart diseases, and cancers. Comparative data on women's health were also a cause for concern as well as abortion rates and abortion-related morbidity and mortality. The health status of the populations was impaired because of poor economic conditions: low quality housing and transport, scarce food and a general shortage of consumer goods, and fast-rising unemployment in several countries. Vaccines were often not available.

Blueprint for health

The Eurohealth programme was designed to help countries to redress the immediate deficiencies that are the source of popular and professional discontent. Eurohealth is a blueprint that individual countries can use to redesign their health systems and reorient their policies. This has practical implications. Decisions taken over the next 18 months will determine the future shape of health systems throughout central and eastern Europe. A unique opportunity now exists to move towards new, more imaginative patterns of health development that do not blindly copy any one system, but make use of the best experience from western Europe and elsewhere.

Activities are carried out in constant cooperation with WHO headquarters in

Geneva. Numerous joint activities have taken place in regard to drugs, AIDS, health financing and human resources training. Other UN agencies, European intergovernmental organizations, non-governmental agencies, industry and health insurance funds are all lending support to Eurohealth and participating in its success.

Better liaison

The countries which have joined the programme are aware that this success depends on a high level of liaison and active cooperation with WHO. Following the successful experience of having a WHO liaison office in Romania since January 1990, similar offices have been set up in Bulgaria, Hungary and Poland, and two are being established in Czechoslovakia. In all cases, the liaison officer is a national who is seconded by the country in question and acts on behalf of WHO. This ensures true commitment and effective coordination with the Eurohealth programme manager at the Regional Office.

There are already encouraging signs that these efforts are truly improving people's health. In many areas, cooperation is developed with the view to initiating directly effective activities. Eurohealth has logically started with efforts to provide direct assistance and mobilize international support for the provision of life-saving and essential drugs, vaccines, supplies and equipment. This need for drugs is part of a wider problem which includes all aspects of production, regulation, prescription and use. Thus the Netherlands has provided Eurohealth with funds to launch and develop national drug bulletins in Czechoslovakia, Hungary and Poland, and a pilot project on information leaflets for patients in Czechoslovakia and Hungary. Both projects are carried out in close collaboration with the national authorities and experts, as a full part of the countries' drug policies.

When it comes to health services reform, we use a three-step approach. First, WHO missions are sent to the field to assess needs and meet with national authorities to review their health services policies. Next, support is provided for initiatives aimed at innovation in local health services. A third level of action is reached through active support to improve efficiency in such technical priority fields as health insurance, management development and health economics.

Eurohealth has also undertaken needs-assessment missions in the area of health promotion in some countries. Healthy Cities networks are being developed, and a project on healthy schools will initiate a collaborative study on health behaviour for schoolchildren.

In the field of sexuality and family planning, WHO is the executing agency for projects of UNFPA (the UN Population Fund), which place emphasis on countering disinformation on modern contraceptives, training the providers, facilitating access to modern contraception, strengthening local contraceptive production and developing networks of women's health associations.

Centre for Environment

Last, but not least, the severity of environmental pollution in these countries and its consequences to human health have been placed under sharp scrutiny. The countries concerned have proved very willing to receive assistance and to cooperate with us in implementing appropriate programmes, in line with the European Charter on Environment and Health, and the new European Centre for Environment and Health will undoubtedly play an important role. ■

Dr Jacques A. Bury is Regional Adviser on Countries in Central and Eastern Europe, WHO Regional Office for Europe, Copenhagen.

Middle East crisis

The involvement of the Regional Office for Europe in the Middle East crisis, sometimes referred to in the media as the "Gulf War", started soon after Kuwait was invaded in August 1990. Immediately upon the arrival in Turkey of the first refugees, who had fears that Iraq would be counter-attacked, the Turkish Minister of Health requested our assistance in several areas related to the crisis.

The most urgent task was to ensure appropriate training of relevant staff to protect the population against the consequences of possible use of chemical or biological warfare, and to deal with possible war casualties. Although this was kept confidential in order not to spread panic among a population which was already under heavy pressure, a first visit was undertaken by WHO experts as early as October 1990, and a second series in January and February 1991. Experts and staff from the Regional Office also joined forces with those sent by WHO headquarters and other United Nations agencies to evaluate both the immediate and future needs in the perspective of any major population flow into Turkey. This resulted in a standardized approach designed to help both the Turkish national authorities and the international community to accommodate, shelter and take care of as many as several hundred thousand refugees.

However, the reality exceeded our worst expectations, and when the vast human exodus took place in early April, it found us incompletely prepared. What the fate of these 1.5 million northern Iraqis would have been if this preparatory work had not been done is difficult to imagine. Of those who fled to the rough mountain areas bordering Turkey and Iran, thousands did not reach the sanctuary they sought. Many children, women and old people perished from cold, hunger, exhaustion or mine explosions.

The international response was considerable, and WHO's European Region played its part. We sent emergency health kits to cover the needs of 200 000 persons for three months, and our experts provided help and advice in hospital care, nutrition, epidemiology and the prevention of communicable diseases. After the repatriation was completed in June 1991, WHO provided supplies to clean up the abandoned camps and prevent environmental pollution.

From abortion to contraception in Romania

by Daniel Pierotti

On Christmas Day in 1989, the Romanian Parliament abrogated the law of 1966 which had made all legal abortions and all modern contraceptive methods impossible. A simple signature representing the will of the people put an end to 23 years of suffering for Romanian women.

By the 1966 law, the former regime hoped to raise the birth rate, which by that year had fallen to 15.6 per thousand. But 20 years later that intention could only be described as a failure; in 1985, the birth rate had fallen back to the same low level, after a brief improvement.

In changing the law, Romania has made abortion available in the obstetric and gynaecological services up to the 12th week of pregnancy, and it has facilitated the introduction of contraceptive techniques, thus joining the ranks of the progressive countries in the rest of Europe.

At the same time, the creation of a private family planning association, the Society for Education in Contraception, and assistance from the specialized agencies of the United Nations and nongovernmental organizations, have opened new perspectives in the field of reproduction.

So where are we 18 months later?

- 992 265 abortions were carried out in 1990, 92% of them legally.
- More than one million abortions are expected in 1991.
- Maternal deaths due to abortion have fallen by more than 60% in one year, and that tendency has accelerated this year.
- 545 women died as a consequence of abortions in 1989; this total fell to 180 in 1990 and will be below 100 in 1991.
- Family planning is just making its first timid appearance after a long sleep; 20 000 women attended the specialized clinics in 1990 and close to 50 000 in 1991.

At this point, we can reach the following conclusions:

- Whatever laws are decreed to deal with reproduction, they will have only a slight effect on a woman who is determined either to continue her pregnancy or to end it.
- The notion of abortion carried out under safe conditions is more important for the health and the life of women than the simple legalization of abortion.
- It is easier to switch from illegal abortion to legal abortion than to introduce the practice of modern and effective contraception.
- Legalized abortion allows a woman to feel secure, but in a passive way.
- Introducing the practice of modern contraception is as complex a process as introducing new technology into a traditional rural context.

The contribution of the specialized agencies in matters of abortion remains marginal and, since gynaecologists have been trained in sophisticated techniques, the risks of the operation remain quite small. The only notable progress made in recent years has been the introduction of methods using aspiration, which are less aggressive than the classical methods.

On the other hand, setting up a programme of modern contraception calls for a considerable effort on the part of the national authorities, who ought to be able to turn to the international organizations for help. Their tasks will include:

- Convincing the medical corps and its clients of the universal superiority of contraception over abortion.
- Ensuring the necessary training of health professionals.
- Developing the right kind of public information programmes.
- Creating acceptable conditions for women to come forward for advice.
- Providing contraceptives in sufficient quantities and at affordable prices.
- Stepping up local production of contraceptives.
- Making audiovisual facilities available nationally.
- Arranging for evaluation techniques which will be essential to observe the progress made.

In March 1990, WHO and the UN Population Fund (UNFPA) started an emergency family planning programme which included the training of personnel as well as the provision of basic equipment and contraceptives.

A World Bank project costing US$ 12.5 million and a second phase of the WHO/UNFPA programme should make it possible to reinforce the efforts made in these first years and to facilitate the transition from abortion to contraception. ■

Dr Daniel Pierotti heads the Sexuality and Family Planning Unit at the WHO Regional Office for Europe, Copenhagen.

Photo WHO/Zafar

Women's health in Europe

by Mireille Didier

As the 20th century draws to a close, we have witnessed a genuine revolution for which women have been waiting for thousands of years: at last it has become possible to control reproduction. From the contraceptive pill to the intrauterine device (IUD), from spermicidal suppositories (which destroy the male spermatozoa) to the good old condom (which has the added advantage of being the only effective way to prevent the sexual transmission of AIDS), there is a wide choice of simple, safe and effective methods for avoiding an unwanted pregnancy.

Good family planning entails an equal sharing of responsibility between men and women.

Proper facilities

Yet women and their partners still need to have access to them and to learn how to use them. Moreover, the psychological and social mechanisms governing the woman's choice as to whether or not to have a child at a given moment are highly complex. This explains why, despite the ready availability of contraceptive methods, we cannot hope to see unwanted pregnancies disappear completely. It is therefore all the more important to make sure that proper facilities are available for women who do not wish to continue with such pregnancies.

Experience proves that, if family planning methods are to be used properly they must be accompanied by genuine sex education provided by professionals and volunteers. Respect for cultural habits and religious convictions, and a kind of apprenticeship in responsibility on the part of both partners, are essential prerequisites for efficacy in this field. In order to ensure that every child born is a wanted child, every woman's right to choose the means for fulfilling her sexual and reproductive life must be respected. ■

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The quality of health care

by Kirsten Staehr-Johannsen

New drugs, new operations and alternative ways to deal with health problems are frequently reported in the press. Some are soon forgotten, others are here to stay. But are they always beneficial to health? Are they always better—or cheaper—than what we had before? Is the patient more satisfied and happy about using them? In other words: is the quality of health care better than before?

WHO's European Region is deeply involved in efforts to study—and to improve—standards of care both in hospitals and in the consulting rooms of family doctors. For example, in conjunction with 11 countries we studied the possible advantages of the insulin pump (see *World Health*, May–June 1991, pages 5 and 11) compared to insulin injections made by patients themselves. Patients were asked their own personal opinion. We also examined data about the costs of the two methods, and of their effectiveness from the doctors' point of view.

WHO's European Region is deeply involved in efforts to study—and thus to improve—the standards of health care.

It turned out that the pump did not bring much benefit for most patients. In some cases, it had some undesirable side-effects, but we were able to improve on the existing treatment. Patients could be taught to check their blood-sugar level and thus decide more easily how much insulin they should inject. We also found that more efforts should be made to help patients to stop smoking and in general to adopt a healthier life-style. The pump itself had some drawbacks, but the study taught us how we could help patients to understand and cope much better with their own condition. Millions of people with diabetes will benefit from the study.

Doctors and nurses, like most people, do not normally like to be *told* that they must change their ways. It is much better to involve them in the studies so that they can participate in the decisions. The computer is an excellent tool for such studies. Health workers can send their information to the researchers, and in return they can read the findings of the study on their computer screens.

We developed a computer program called *WHOcare* to study wound infections in hospital patients who had had an operation. The findings resulted in guidelines that were of immediate use to surgeons, as well as to hospital and health authorities. Better training of the doctors, nurses and others was an important recommendation.

Everyone has his or her own ideas and impressions about what to do to solve a health problem. Studies of the quality of health care help us to come to common agreement about what really works to the satisfaction of the health staff, but most of all to the benefit—and satisfaction—of the patients. ■

Dr Kirsten Staehr-Johannsen is the Regional Adviser on Quality of Care and Technologies, WHO Regional Office for Europe, Copenhagen.

Photo WHO/T. Farkas

This child is measuring the level of glucose present in his urine.

The elixir of life

by Jack Apfel

When I was first diagnosed as diabetic in 1962, it was almost impossible for a diabetic on insulin to get life insurance, except at the most abnormal, penal rates. Today, we can obtain insurance at almost normal premiums, even though insurance companies are not in the habit of throwing their money away! They can see the improvement. Today we, the diabetic community, feel more in control and know that we can have a normal life. We can fit our diabetes into our lives and not fit our lives into the diabetes.

This tremendous achievement is one result of the improved health technologies which are of benefit to all. Glucose test strips are simple and inexpensive, yet to me they are the elixir of life. Because thanks to them I can monitor my own blood sugar, and I can vary my diet and dietary requirements accordingly. This is why, to the diabetic on insulin, the availability of blood glucose monitoring equipment has been almost as important as the discovery of insulin. We know what the unavailability of such basic equipment may mean in terms of quality of life.

I was very fortunate to be able to visit Romania immediately after the 1989 revolution to see for myself the problems there. Although they had excellent, dedicated doctors and health workers, I was horrified to see the number of patients who had suffered amputations, who were blind, who suffered other complications from diabetes and who clearly were no longer able to perform a useful job or enjoy a full and happy life-style.

How can this be today? Those who are governing us should be asking this question themselves. I refer not only to people from central and eastern Europe, but also to those from sophisticated "Western" economies. I understand that in one of the latter countries (perhaps the most sophisticated and the wealthiest) there is a problem in obtaining free distribution of glucose strips because the health insurance companies say they are too expensive. Too expensive to whom is the right question to ask. Improved and affordable health procedures can work wonders everywhere, and there is still a lot to do if we want this simple fact to be acknowledged. ■

Mr Jack Apfel, 55, has been a diabetic for the last 30 years. He describes himself as "an ordinary patient" and is Vice-Chairman of the International Diabetes Federation in Europe and President of the European Diabetes Union, 17 Nottingham Street, London W1M 3RD, England.

What the patient thinks

What is the best way to treat bronchitis? Doctors have their opinions. But so too do the patients, and their relatives. The Quality of Care and Technologies programme of WHO's European Region recently launched in France two study projects on acute tonsillitis and on the variations in diagnosis, treatment and outcome of severe broncho-pulmonary infections as observed in general practice.

The studies, under the French name of "Quali-soins", are based on the use of the Minitel—a computerized telephone network—to which several millions of households and professionals are connected. For both projects, about 1000 general practitioners have agreed to review three to five patients each. Data on diagnosis, therapy, clinical and social outcome (including duration of treatment and days of absence from work or school) are collected and sent to the researchers' central computer.

Each patient is also invited to answer questions that will ensure that his or her viewpoint is taken into account. The response has been very good, and more than 90% of the people involved participated within a month of the project starting.

This type of study is both quick and reliable. The results should enable policy-makers, physicians and manufacturers of drugs and health equipment to agree on guidelines for dealing with these diseases, which are very common yet are responsible for much absence from the workplace and the schoolroom.

Water: a fragile resource

by Xavier Bonnefoy

It is often said that Europe, especially compared with other, less privileged continents or regions, is overdeveloped. Like all clichés, this contains an element of truth, but behind the façade of privilege there are large areas of underdevelopment.

Is it acceptable that even today—a little over eight years from the year 2000—more than ten million Europeans have to walk for more than ten minutes to reach a source of water, drinkable or otherwise? Can we believe that less than 30% of the waste water produced in Europe today is subject to purification? In fact, although European countries can boast the most advanced techniques for the conveyance and treatment of drinking water, and although most can afford them, we must all radically change our collective attitude to water.

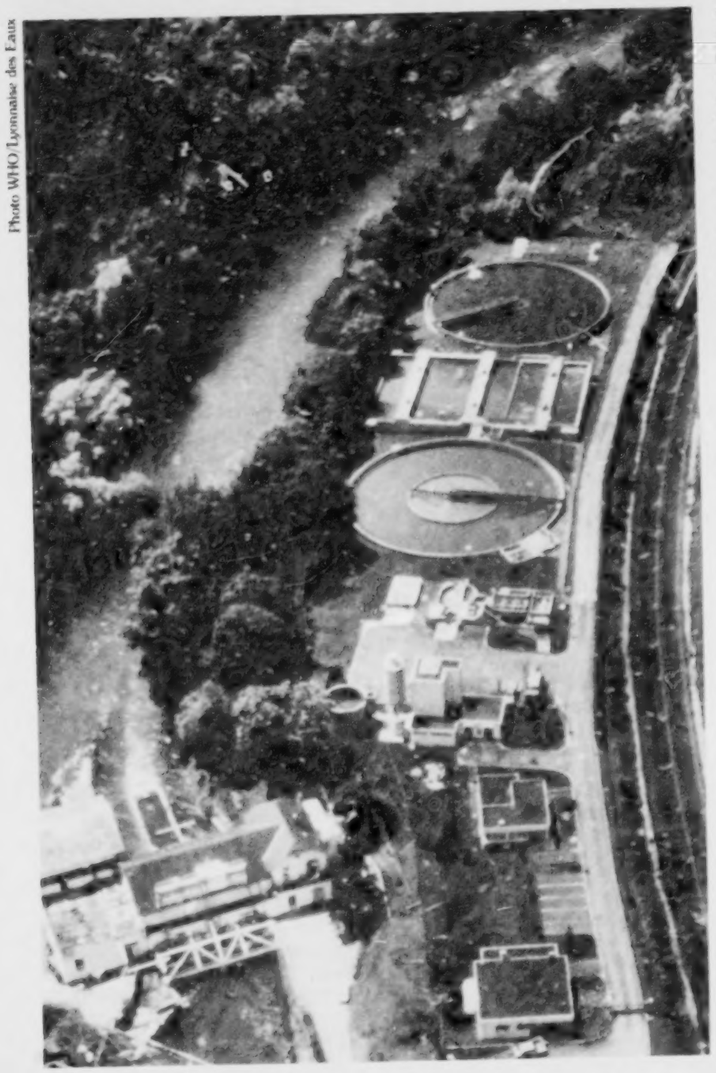

Photo WHO Lyonnaise des Eaux

As in centuries past, we still like to pour our waste into the nearest lake. We are reluctant to treat the sewage, because that costs a lot of money. We also want to be able to swim in that same lake, in safety, and to build on its shore a food-processing plant, which may be indispensable to the economic development of the region. All these wishes, which on the face of it are reasonable, form a mass of contradictions which are hard to reconcile.

A fact of daily life

Europeans have all that it needs to ensure the success of a water policy which makes the right to clean water—if not something to be taken for granted (which would be dangerous)—at least a fact of daily life. This is possible since Europe, compared with other regions, has exceptionally favourable climatic and geographic conditions: relatively abundant water resources, a dense and evenly distributed surface network, and a temperate climate. It is possible also because most of the countries in the Region have the requisite administrative structures, means of production and management, and even sufficient financial resources.

We have the know-how. And the resources. What we perhaps lack is realism.

We cannot blithely congratulate ourselves on the near disappearance of the epidemics of cholera or typhoid that still ravage other continents, yet remain blissfully unaware of the real, water-borne "epidemics" afflicting Europe today. Entire regions are still contaminated with lead or fluoride. Our water conveyance systems are better developed than in other regions, yet, as we have seen, they do not serve all Europeans, and hundreds of them lose in transit more than half of the water they are supposed to bring to the user's tap!

Purifying the water is not the end of the story; we have to radically change our attitude towards this natural resource.

Europe is therefore exposed to risks that are unknown in other continents. Its resources are more threatened and fragile each day, and it cannot afford to delay action. We have options that would support both economic development and the preservation of water, which is an essential capital for public health and for life in general.

In the first place, we should work for greater solidarity between countries. Water is a common heritage, and its preservation has to cross geographical and political boundaries. We must also devote more resources to the maintenance and renewal of existing water, otherwise the progress achieved on the one hand will be cancelled out by recession on the other. More resources are needed for water research (exploitation and treatment), where there are unexplored fields of study.

Last but not least, we should mount an unprecedented international campaign to change the way we use water. Governments obviously must face up to their responsibilities as regards the infrastructure, for the distribution and treatment of water. Individuals, too, should act: admit that water is rare, and that it will become still rarer unless we are careful; realize that preservation of water is preservation of our future; accept the idea of paying what it is worth, even if there are sharp price rises in the short term.

Water seems the most humdrum of resources—clear, colourless, odourless and tasteless—yet it gives us the savour of life. At national level, voluntary policies should aim to make the best use of existing potential, in terms of quantity and quality. The most underprivileged Europeans should be given permanent access to good water.

As individuals, we must participate in this indispensable effort by changing our habits and our way of thinking about water: stop wasting and needlessly polluting water, and accept the need to pay more to have better supplies, for a longer time. In effect, we did not inherit the earth from our parents: we have it on loan from our children. Each of us might keep this concept in mind in all our daily tasks. ■

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What does WHO/EURO do?

WHO/EURO has four main roles:
- to help spread existing knowledge by identifying innovative and improved approaches to health care in Member States;
- to promote research in health;
- to act as a catalyst in promoting the development of national health policies and programmes towards the principles of health for all; and
- to improve cooperation and coordination between international organizations active in health matters.

Through EURO, Member States exchange information on:
- new discoveries, such as immunization against measles/mumps/rubella;
- serious communicable diseases, such as AIDS;
- damaging substances, such as tobacco;
- and new scientific results.

In addition valuable knowledge and experience are continuously shared.

Responding to disasters

by J. Oltio Espinoza

Whether disasters are of natural origin or man-made, their effects in a country's life can be detected for months, and sometimes even years. It is therefore essential that any support operation be designed and implemented with a long-term perspective.

This is why all the interventions originating in the Regional Office to meet such situations extend from a *preparedness phase* (i.e., adoption of *ad hoc* action plans and development of adequate human resources) to a *post-disaster* support programme that includes preparing and carrying out—jointly with national and international counterparts—medium- and long-term rehabilitation plans for the health sector.

Of course the main thrust of our action takes place immediately after the disaster itself, during the so-called *disaster phase*. First of all, both the extent of the disaster and its potential consequences on the health of the population have to be assessed. This is usually done by a field mission which is sent within hours. A second step is to provide technical advice to solve the most urgent problems, and avoid stumbling blocks which could originate from a lack of coordination. Only then can we most efficiently mobilize relief assistance, either by relying on our own readily available but limited resources, or by calling upon potential donor countries and/or relief agencies, whether within the United Nations system or among nongovernmental organizations.

It may look like a complex process, but this sequence is essential in order to achieve coordination of effort and ensure efficiency. Working hastily can also lead to slowing down.

As soon as the report of a disaster reaches us—and sometimes before the disaster itself when it can be anticipated, for instance in an international crisis situation—an internal task force is activated within the Regional Office. All relevant specialists from the Regional Office are involved and participate in both the assessment of the emergency situation and the first steps of assistance.

A group of external assessors is also kept on 24-hour notice, and is of priceless support to the task force; its members' competence ranges from seismology to environmental pollution, and includes all the psychosocial aspects involved in emergency situations. Beside the fact that they are invaluable resource persons and can provide technical advice and support, these assessors are ready at any time to accompany a WHO field mission.

We also rely on a network of WHO collaborating centres, usually national institutions which have signed an agreement with us to carry out a variety of activities at national level for the development of programmes on disaster preparedness, relief and rehabilitation. They also collect and analyse data on disasters, and frequently participate in the training of personnel. ■

Mr J. Oltio Espinoza IS Regional Adviser, Accident Prevention and Disaster Preparedness, WHO Regional Office for Europe, Copenhagen.

Where help was needed

Earthquakes account for many disasters in the relief of which the Regional Office has been involved. Many people will remember Agadir (Morocco) in 1960, Skopje (Yugoslavia) in 1963, Van and Erzurum (Turkey) in 1975 and 1983, El-Asnam (Algeria) in 1980, Kalamata (Greece) in 1986, and most recently in the Soviet Republics of Armenia (1988) and Georgia (1991).

Among recent man-made disasters in this Region, we can mention the toxic oil syndrome (Spain) in 1981, and the Chernobyl (USSR) nuclear accident in 1986, when the Regional Office was put in charge of assessing the immediate health risks connected with the radioactive fallout.

National or international crises can also lead to disaster situations. Massive migrations between Bulgaria and Turkey (1989), the upheaval in Romania (1989–90), and the crisis in the Middle East, known in the media as the "Gulf War" in early 1991 are typical instances when the Regional Office was requested to help Member States in facing dramatic problems.

After a severe earthquake in Turkey, the survivors rapidly installed an emergency water supply, with technical cooperation from WHO.

Photo WHO EURO O. Espinoza

USSR: learning to think constructively

by Igor Aleksandrovic Serkov

This Spring I was walking through one of the beautiful parks of Kiev, talking with a friend, when suddenly he said, "All you hear now in Kiev is the cawing of crows". I listened. There were dozens of birds singing every kind of birdsong. My friend did not hear them. Then I remembered that when I came to Kiev last year everyone was complaining about their thyroid glands. This year they all had sore feet. And they had only one explanation: radiation from Chernobyl. I know Kiev too well to try to disabuse my friends and acquaintances of their fears, which are simply inexplicable to outsiders.

The Chernobyl disaster has clearly become a focus for all the political, economic, ecological and medical problems that are tormenting Soviet society today. Sociological surveys conducted by various centres for public opinion research have produced astounding results.

A third of those canvassed are convinced that there will be no improvement in their lifetime. A further third believe that any improvement will be insignificant. Fully a quarter think that things will only get worse.

While 25% believe that people have already run out of patience, 21% think that people will put up with the situation only for another few months and 23% are of the opinion that the patience of the Soviet people is infinite.

These results are endorsed not only by sociologists and politicians, but by doctors too.

There are regular outbreaks of lice infestation in the Soviet Union today, especially in schools and kindergartens. Mihail Narkevich, head of the Central Epidemiology Unit of the Soviet Ministry of Health, gives this explanation: "Admitting the extent of lice infestation would be like acknowledging the trouble that society is in. This is why such matters were hushed up in the past. In recent years, this particular health problem has taken on alarming proportions that bear witness to the scale of social upheaval in our country. Lice infestation affects first and foremost people who are in a state of depression. The main underlying cause of such outbreaks is disorganization, uncertainty and fear of the next day."

This example shows clearly enough that many Soviet citizens are living in constant expectation of calamity, with a feeling that a disaster is already upon them and its end is nowhere in sight.

It is hard to disagree with People's Deputy Aleksej Jablokov, a corresponding member of the Academy of Sciences of the USSR, when he exclaims, "Ecological ignorance in our country often goes hand in hand with ecological recklessness, both of which lead to ecological crime." Yet it is just as hard to resolve the dilemma that would be posed by closing down, on ecological grounds, chemical plants producing drugs which are in desperately short supply. Death from disease related to air or water pollution or death from drug shortage? This is the kind of choice the Soviet people are often faced with.

"I was recently in the Soviet Union", says Wilfrid Kreisel, Director of the Environmental Health Division at WHO headquarters in Geneva, "and my first impression was that they only began to think about ecology and people's health quite recently. Now times have changed, and people realize that they must not only work but also live. But I noticed too that many Soviet people are much too pessimistic about the future. With that kind of outlook nothing can be done. It's demoralizing.

"You have to assess the situation without panic or hysteria, then establish priorities and act. Given the present drug situation in the Soviet Union it would be crazy to close pharmaceutical plants. Life goes on even where there is harmful pollution, but without drugs people simply die. Furthermore, drug shortages cause panic, and no one knows what that can lead to. Of course, particularly dangerous factories must be closed, but first one must ascertain which are essential and which are not."

This WHO expert is, of course, correct. And yet . . . for many years the Soviet people have lived in ignorance of what was going on in their own country. They were led to believe that fires, floods and earthquakes caused neither loss of life nor serious damage. The main aim of Soviet propaganda was to create an atmosphere of well-being. Now the country is reaping the bitter harvest of that policy. Each new disaster shows up the inability of the Soviet people to cope with catastrophe. Each time the only hope is the army, which is not able to act with equal success in every situation. And the victims in their ignorance can make matters worse. There are amazing instances from Chernobyl: one of many examples is that none of the firemen had been trained in fighting fires in radioactive zones. The rescue workers and firemen had no idea of how serious the risk of contamination was.

The Soviet Union today is faced with a possible new danger: huge numbers of people could become refugees if civil disturbances in various republics deteriorate. And so far neither the legal nor the medical aspects of how to cope with such colossal movements of peoples have been worked out.

The WHO Constitution promises to provide the necessary aid to member states in emergencies; its regional offices have their own programmes of emergency preparedness and response. The Soviet people are pinning their hopes on the assistance of international organizations, but they may be hoping for too much. All the same, most of the Soviet population realize that their problems will not be resolved without extensive international support. They cannot do without the expertise and experience of WHO.

As Wilfrid Kreisel says, "I have been in situations where people felt there was no hope, that the end of the world had come; and yet a way out was always found. You just have to think positively. There is a lot that people can do, however hard their life is." The dearth of constructive thinking is really one of the most serious shortages in the USSR today. But we want to believe that the help of the international community will enable us to overcome it. ■

Mr Igor Aleksandrovic Serkov is Deputy Editor of *Nedelja* weekly magazine, Puškinskaja ploščad 5, Moscow, USSR.

NEWS PAGE

Editor: Philippe Stroot

Baby-friendly hospitals

WHO and UNICEF have launched a new initiative aimed at promoting breast-feeding in hospitals. The plan was adopted during a meeting of paediatricians, obstetricians, community health workers and members of nongovernmental organizations held in Ankara, Turkey, on 28 June 1991. In order to promote the adoption of the "Ten Steps to Successful Breast-feeding" by hospitals and maternity services and to get the Ten Steps rapidly into action, establishments which adopt them will be designated as "Baby-friendly".

The Ten Steps call for every facility providing maternity services and care for newborn babies to:

1. Have a written breast-feeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breast-feeding.
4. Help mothers to initiate breast-feeding within a half-hour of birth.
5. Show mothers how to breast-feed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless *medically* indicated.
7. Practise rooming-in—allowing mothers and infants to remain together—24 hours a day.
8. Encourage breast-feeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breast-feeding infants.
10. Foster the establishment of breast-feeding support groups and refer mothers to them on discharge from the hospital or clinic.

The ten steps can be found in *Protecting, promoting and supporting breast-feeding: the special role of maternity services*, a joint WHO/UNICEF statement. WHO, 1989. This publication is available in Arabic, English, French and Spanish (price Sw.fr.6) and is being prepared in 23 other languages.

A resolution adopted last year by UNICEF called on "manufacturers and distributors of breast-milk substitutes to end free and low-cost supplies of infant formula to maternity wards and hospitals by December 1992," in order to reduce the detrimental effect that this practice has on breast-feeding.

Following a meeting in Geneva with Dr Hiroshi Nakajima, Director-General of WHO, and Mr James Grant, Executive Director of UNICEF, the President of the International Association of Infant Food Manufacturers (IFM), Mr Peter Borasio, confirmed that the Association's members agreed with the goal of ending this practice, and pledged their full cooperation in these efforts. ■

Making hospitals baby-friendly.

Photo WHO/E. Rice

Photo WHO/H. Aranden

Strengthening the research capacity of developing countries.

Trials of vaccines against AIDS

WHO has selected four developing countries for the study of potential vaccines to prevent infection with the human immunodeficiency virus (HIV), the virus that causes AIDS. The four countries—Brazil, Rwanda, Thailand and Uganda—will receive support from WHO in strengthening their capacity to undertake vaccine studies. This will ensure that, when a vaccine against HIV infection is ready to be tested in large-scale studies in people, developing countries will be in a position to participate.

At the present time, experimental vaccines are being tested in small numbers of human volunteers in North America and Europe to determine their safety and their ability to produce an immune response. Once an experimental vaccine has been shown to be safe and to induce an immune response, the next step is to carry out vaccine effectiveness studies in which up to a thousand or more volunteers who are not infected with HIV are vaccinated and studied to determine whether they have been successfully protected. It will be important to test promising vaccines in countries where they will be used, since different HIV strains are found in different parts of the world. In other words, a vaccine which is suitable for use in one country may not be effective in another that has different strains of HIV.

Therapeutic vaccines against HIV, that is, vaccines that may be useful in preventing the onset of AIDS in persons already infected with HIV, are also being studied in developed countries. Should these trials suggest that such vaccines are effective, they could also be tested in countries selected by WHO.

Some industrialized countries are also establishing national centres for vaccine trials and are working in partnership with developing countries to strengthen centres for perfecting HIV vaccines. If effective vaccines are developed, WHO is committed to doing all it can to ensure their availability worldwide. Discussions have already started with vaccine manufacturers, through the International Federation of Pharmaceutical Manufacturers' Association, to explore ways in which WHO and vaccine manufacturers can collaborate in vaccine development and plan for eventual worldwide distribution of HIV vaccines. ■

Worldwide mobilization against malaria

About 150 officials working in malaria control in over 50 African, Asian and Latin American countries met from 21 to 25 October 1991 at the WHO Regional Office for Africa in Brazzaville to pave the way for a new global strategy against malaria. Representatives of cooperation and development agencies of the UN system and bilateral bodies also attended the meeting.

Participants at this interregional conference called urgently for the World Ministerial Conference on Malaria, to be held in Amsterdam, Netherlands, in October 1992, to mark the beginning of a new thrust and to adopt a realistic global strategy to fight this disease.

Once again this year, more than one million lives will be lost to malaria throughout the world, the great majority being children aged under five in tropical Africa. According to WHO estimates, more than 110 million people contract the disease every year, and 90 million of them come from the African region. At present, almost

half the world's population in more than 100 countries are threatened by malaria, which tops the list of the most severe tropical diseases.

In the face of this serious public health problem, WHO is launching a new world initiative against the disease, which draws lessons from past efforts on the part of the entire international community in this field, whether in the countries concerned, bilateral agencies or international organizations.

As one WHO official put it: "After the malaria eradication efforts made in the 1950s and the 1960s, the international community slackened its pace. Poverty, lack of infrastructure, and resistance to drugs and insecticides have led to persistence of the disease. In some areas, the malaria situation has worsened considerably, and it can only be conquered through the application of a range of measures."

Photo WHO/S. Lindsay

This trap to catch mosquitos is placed near a person sleeping under a bednet.

The new strategy advocated by the participants in the Brazzaville conference is based on three fundamental principles: better case management with early diagnosis and rapid treatment; selective application of mosquito control methods according to the local ecology; and prevention and control of epidemics through epidemiological monitoring and emergency intervention.

As long as the international community is not committed to this fight at the highest political level and in an explicit manner, good results are unlikely to be obtained. This is why WHO hopes that the Amsterdam Conference will unanimously mobilize the international community in favour of malaria control. ■

Newsbriefs

• **"Tobacco-free workplaces: safer and healthier."** *This is the slogan chosen by WHO for the next World No-Tobacco Day, to be celebrated on 31 May 1992. The Day will offer an occasion to draw attention to the risks of smoking at work, and to the fact that everybody should have the right to work in a smoke-free environment. The workplace is where people spend most of their waking lives. So the least that everybody can ask is to be able to breathe healthy air there, unpolluted by tobacco smoke.*

• *An International Jury met on Monday 25 November 1991 at the School of Decorative Arts in Geneva, to select a poster for World No-Tobacco Day on 31 May 1992. A poster competition had been organized among fourth-year students of this prestigious school. They had been asked to illustrate the theme "Tobacco-free workplaces" in a poster that would be culturally acceptable to all countries. The winner, Samuel Bruder, will receive a Tobacco or Health medal and his poster will be translated into many languages.*

• **Mobilizing global action against ARI.** *In order to appeal for worldwide support for action against acute respiratory infections (ARI), an International Consultation on the Control of ARI was held in Washington, D.C., from 11 to 13 December 1991. These diseases are the number one cause of child mortality in the world, killing more than four million children aged under five every year, mostly because of pneumonia. ARI need not be a major killer, since simple treatment, provided it is administered early, can save lives. But this effective treatment requires access to trained health workers who are adequately supplied with a small number of essential drugs—and this is still far from being the case everywhere.*

• **Maternal mortality: contrasting estimates.** *Over 500 000 women still die each year in certain parts of the world during pregnancy or in childbirth. New data collected by WHO show that the situation has slightly improved in Asia and in parts of Latin America. However, the situation remains critical in sub-Saharan Africa, where a pregnant woman is at 75 times more risk than a European woman of losing her life in giving birth. Two WHO specialists, Carla Abou Zahr and Erica Royston, have just published a set of statistics on maternal mortality in 117 developing countries, with the title* Global factbook on maternal mortality. *This may be obtained, in English only, from Distribution and Sales, WHO, 1211 Geneva 27, price Sw.fr.50/US$ 45 (special price for developing countries Sw.fr.35).*

• **The once and future killers.** *The concept of healthy living has been gaining ground everywhere since the 1980s. As a result, mortality from cardiovascular diseases has declined in a number of industrialized countries, thus setting a good example for all governments and citizens to follow. However, these heart diseases still remain the No. 1 killers worldwide. In particular, death rates are on the rise in eastern Europe and in the developing world. These facts provide the framework and the title* Heart diseases: the once and future killers *for WHO's new 17-minute video. This is available as a VHS video cassette (in English only) from Distribution and Sales, WHO, 1211 Geneva 27. (Price: Sw.fr.40/US$ 36, postage and handling included.)* ■

In the next issue

The slogan chosen for World Health Day 1992 is "Heartbeat—the rhythm of health". The January–February 1992 issue discusses what can be done to prevent heart disease. It will also include a health game.

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All for health

This poster, designed by Ulla Frellsen as one of six published by the Danish Committee for Health Education on the occasion of the 40th anniversary of WHO in 1988, is a European contribution to the goal of Health for All by the year 2000.